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ABSTRACT

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Running head: PROMOTING SAFE SEX BEHAVIOR

C.A.M.P.: A Community-Based Approach to Promoting Safe Sex Behavior in Adolescence

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Abstract

The primary goal of this study was to assess the Community Awareness Motivation Partnership (C.A.M.P.) theater intervention based on the behavioral ecological model. C.A.M.P. addresses the role of contraceptive use in safe sex behavior through an informative and entertaining culturally relevant dramatization program. Adolescents (N = 1613) between the ages of 11 and 18 (M = 13.31, SD = .76) received the intervention, and 961 participants completed both pre and posttests. The primary ethnicity of this sample is Latino (78.5%, n = 1039), many of whom are first generation immigrants. Results indicate that the intervention increased participants' knowledge regarding the role of contraceptives in preventing STIs. Participants' intentions to delay intercourse and use contraceptives increased after the intervention. The findings indicate that participants felt more comfortable talking with their mother about sexual issues post-intervention. These results suggest that a brief theater intervention can be effective in impacting the safe sexual behavior of adolescents.

Key words: Latino, ethnic, adolescents, community-based intervention, theatre, sex education

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C.A.M.P.: A Community-Based Approach to Promoting Safe Sex Behavior in Adolescence

In 1999, over 50% of high school students in the United States reported having had sexual intercourse (Centers for Disease Control and Prevention [CDC], 2000c). Although fewer adolescents each year are choosing to have sex (CDC, 2000a), those that do are becoming sexually active at increasingly younger ages (Brewster, Cooksey, Guilkey, & Rindfuss, 1998; CDC 1997, 2000c). Latino adolescents are significantly more likely than EuroAmerican adolescents to become sexually active before the age of 13 (CDC, 2000c). Among Latinos, the CDC reports that approximately 10% have sexual intercourse before the age of 13, while 5% of EuroAmerican adolescents report having sexual intercourse before the age of 13.

Sexually active adolescents in the United States report infrequent use of contraceptives. When sexually active adolescents report contraceptive use, condoms are the most frequently used method (CDC (2000c). CDC reports that about half of sexually active adolescents report having used a condom at the time of their last intercourse (CDC, 2000c). Latino adolescents are significantly less likely to use contraceptives than any other ethnic group (CDC, 1997, 2000b, 2000c). Instances of early sexual activity among Latino adolescents and infrequent use of contraceptives places this population at high risk for early pregnancy and sexually transmitted infections including HIV and AIDS.

Unprotected adolescent sexual activity also leads to an increased risk of experiencing early pregnancy. Each year, almost one million adolescent women become pregnant, 78% of which do so unintentionally (National Campaign to Prevent Teen Pregnancy [NCPTP], 2000a). The United States has the highest rate of teenage pregnancy of all industrialized nations (NCPTP). Aside from potentially creating socio-economic difficulties, early pregnancy places some young women at higher risk for medical complications. The infants of these young women

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may also be at greater risk for premature birth, low birth weight, physical and neurological defects, and mortality (Bozkaya, Mocan, Usluca, Beser, & Gumustekin, 1996).

In addition to early pregnancy, unprotected intercourse places adolescents at increased risk of disease contraction. Four million adolescents become infected with a sexually transmitted infection (STI) annually (Office of Disease Prevention and Health Promotion, 1999). Likewise, the CDC (1998) reports that approximately 656,900 adolescents are currently infected with the HIV virus, with minority youth having a greater prevalence of infection. It is important to note that this number only considers individuals who have been tested and found positive to have the virus. Therefore, this number may actually be an underestimate because it does not include adolescents who have been tested, or whose test resulted in a false negative for the virus.

The Role of the School as an Optimal Intervention Site

In response to the potential public health concerns of early sexual activity among ethnic youth, researchers and public health professionals have developed sex education prevention and intervention programs targeting adolescents. Prevention/Intervention programs can take place in many settings, such as communities, churches, schools, and through many outlets, including television and radio public service announcements (Kalichman et al., 2001). School settings in particular have been identified by community psychologists and public health professionals as ideal locations in which to implement safe sex intervention programs (Kirby, 2000). The majority (95%) of adolescents in the U.S. regularly attend public schools, which allows researchers to access a large population of adolescents at one time (Kirby, 2000). Youth spend a great deal of time in school and are socialized in a school environment. The ability to contribute to the socialization of youth makes school settings an ideal place in which to implement interventions (Kirby, 1985, 2000). In addition, youth enrolled in public schools are the most

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accurate representation of a healthy adolescent population. Therefore, interventions implemented in school settings have the potential to impact adolescents before they become sexually active as well as adolescents who are at high risk of becoming pregnant or contracting STIs, including HIV (Kirby, 2000).

The Role of School-Based Sex Education Programs

In addition to the implementation of public health interventions, policies have been executed requiring U.S. public schools to establish formal sex education programs (Finkel & Finkel, 1985). The majority of sex education programs seek to increase adolescents' current levels of knowledge about HIV and STI transmission and prevention and early pregnancy, with the goal of subsequently increasing adolescents' safe sex behavior (Kirby, 1985). In these programs, adolescents are taught about the consequences of risky sexual activity, and how to prevent contraction of STIs (including HIV) and unwanted pregnancy. Currently, about 80% of adolescents receive some form of sex education in school (Adams, Schoenborn, Moss, Warren, & Kann, 1995).

However, the majority of these sex education programs have a sole emphasis on discussing the biology of human sexuality and reproduction. Less than 40% of adolescents receive instruction on how to obtain and use birth control (Harris, 1986). Despite the evidence that instruction on how to obtain and use condoms can greatly improve the effectiveness of safe sexual health interventions (Bandura, 1992), only 0.3% (n = 2,688) of U.S. public elementary and secondary schools have condom distribution programs (Kirby & Brown, 1996; National Center for Education Statistics [NCES], 2001). The U.S. Department of Education, NCES (2001) reported that in the year 2000 there were 46.9 million children and youth enrolled in public schools. If we apply the possible availability of condom distribution programs to this

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national number it implies that approximately 138,000 youth receive these services (NCES).Indeed, many researchers have noted that knowledge alone is insufficient in and of itself to produce behavioral change (Bandura; Hogben & Byrne, 1998; Kirby, 1985, 2000; McDermott, 1998).

In addition, marked gender and ethnic disparities in sex education programs exist (Adams et al., 1995). Adolescent females are less likely to receive sex education in school (Adams et al.). However, females are more likely than their male counterparts to discuss sexuality with an adult family member (Adams et al.). Despite the potential advantages of communication with family members, parents and other informal sources of sexual health information often hold incorrect or insufficient knowledge about STIs and safe sex practices. Like female adolescents, ethnic adolescents are less likely to receive sex education in school than EuroAmerican adolescents (CDC, 2000c). Hofstetter and associates (1995) report that ethnic adolescents are more likely to rely on television (a conservative and often inaccurate source) for information on safe sex and HIV/AIDS information than EuroAmerican adolescents. The current state of Latino adolescent sexual health—how do we know this is so, what does poor health mean, we need some other sentence describing this before this sentence stresses the need for increased sexual health promotion programs that specifically target this population (Marín, Tschann, Gomez, & Kegeles, 1994; Workman, Robinson, Cotler, & Harper, 1996; Yep, 1996). Thus, some researchers, educators, and public health administrators have suggested that public school sex-education programs could be augmented with non-traditional components to increase their effectiveness.

Non-Traditional Intervention Programs

Due in part to the realization that traditional sex education programs are not significantly improving the safe sex behavior of Latino adolescents and other ethnic groups, many community psychologists have worked to establish alternative sex education curricula. Non-traditional programs have been introduced in school settings in recent years to augment traditional approaches to sex education. These programs seek to increase the likelihood that safe sexual practices are carried out by addressing cognitive, ecological, and social barriers to the practice of safe sex behaviors. Often, these health promotion programs exceed basic lectures about human sexuality and reproduction by including interactive components. These programs are often community-based, enlisting individuals from the target population to assist in program design, administration, and evaluation, an approach that not only teaches adolescents about safe sexual behaviors, but also has the ability empowers them to make healthy sexual decisions. There are several components of non-traditional sexual health promotion programs that past public health professionals, community psychologists, and researchers have found increase the effectiveness of these programs:

1. *Grounded in Theory.* Past research suggests that the most effective non-traditional sexual health promotion programs are grounded in psychological or sociological theory. Most notably, the behavioral ecological model (Hovell et al., 1994), which is an extension of social cognitive theory (Bandura, 1992), has been successfully applied to non-traditional sexual health promotion programs. The behavioral ecological model proposes that behavior, cognition (such as efficacy and perceived norms), and one's environmental context mutually reinforce one another in a triadic relationship, and that this relationship can describe and predict adolescent risky-sex behaviors (Hovell et al.). This theory suggests that

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intervention efforts should focus on impacting adolescents' cultural and peer reinforcements to promote safe sex behavior.

2. *Community Educators.* Non-traditional interventions that use peers from the community as sexual health educators have been found more effective than intervention programs using unrepresentative educators, such as teachers and doctors (Card, 1999). Adolescents often feel invincible, and perceive STIs as "adult" diseases (Palmer, Boardman, & Bauchner, 1996). These beliefs may put adolescents at increased risk of engaging in unsafe sexual behavior (Langer & Tubman, 1997; Steers, Elliot, Nemiro, Ditman, & Oskamp, 1996). Using age-appropriate educators from the surrounding community helps to make the intervention poignantly realistic to the audience, and helps to combat feelings of invulnerability prevalent in adolescent populations. Furthermore, a community-based approach can lead participants to feel connected to the intervention and empower them to continue learning about the intervention topic, even after the program has formally ended.

3. *Cultural Competency and Appropriateness.* Many researchers have noted that sexual health promotion programs are much more effective when they are culturally relevant to the target audience (Gillmore et al., 1997; Jemmott, Jemmott, Fong, & McCaffree, 1999; Kim, Stanton, Li, Dickerson, & Galbraith 1997; Siegel, DiClemente, Durbin, Krasnovsky, & Sabila, 1995; Stevenson, & Davis, 1994; Stevenson, Gay, & Josar, 1995). Following from an ecological model, having educators who are culturally representative of the target population goes hand in hand with having peer educators drawn from the community. Kim

and associates, in a quantitative review of 40 AIDS intervention programs, found that the implementation of culturally-based interventions significantly decreased adolescent participants' number of sexual partners and increased their intent to use contraceptives.

4. *Implemented Before the Onset of Sexual Activity.* Previous HIV/AIDS intervention research suggests that interventions that are implemented during early adolescence, before age 15, are most effective. Sexual health promotion programs are generally introduced to adolescents in high school. However, numerous researchers have suggested that this education may be occurring too late to be of any true public health benefit (O'Sullivan, Jaramillo, Moreau, & Meyer-Bahlburg, 1999). In prior studies, it has been found that less than half of the adolescents surveyed had received sexual health education before their first intercourse (Morton, Nelson, Walsh, Zimmerman, & Coe, 1996; Urban Institute, 1992). Furthermore, focus groups have found that both parents (Rafferty & Radosh, 1997) and adolescents (Palmer et al., 1996) feel that sexual health education comes too late to be effective.

Researchers have found that non-traditional, skill-based programs are a more appropriate alternative to traditional sex education programs for transmitting safe sexual knowledge to adolescents (Card, 1999; Harding et al., 1996; St. Lawrence, Jefferson, Alleyne, & Brasfield, 1995). In one study comparing the effectiveness of educational versus skill-based training, St. Lawrence and associates (1995) randomly assigned sexually active adolescents to receive either skill-based or traditional education-based training. These participants were tracked for six months to see assess whether they received treatment for a STI. The findings indicate that

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participants receiving skill-based training were significantly less likely than participants receiving education-based training to have obtained treatment for an STI within the six months after receiving the training. These findings, although preliminary, do suggest that skill based non-traditional sex education is more effective at decreasing the risk of STI contraction than education-based curricula.

C.A.M.P.: A Non-Traditional Intervention to Promote Safe Sexual Health Practices

For the past four years, the authors have been involved in designing and implementing non-traditional sexual health promotion programs geared for ethnic (predominately Latino) adolescents in Los Angeles County. C.A.M.P. is a non-traditional intervention program designed to increase safe sexual health practices among Latino adolescents. The primary aims of the C.A.M.P. Teen Theater program are to: 1) increase knowledge about sexually transmitted infections, early pregnancy, and HIV/AIDS; 2) increase teen-teen and teen-parent communication about sexual issues; 3) promote the role of condoms in preventing STI/HIV contraction and early pregnancy; and 4) provide the option of abstinence or consistent condom use as a method of preventing STI/HIV contraction and early pregnancy.

The C.A.M.P. Teen Theater program accomplishes these aims by implementing a community-based, informative and entertaining dramatization program based the behavioral ecological model (Hovell et al., 1994). The behavioral ecological model posits that adolescents can learn information about safe sex, as well as safe sex practices and negotiation/social skills; from vicariously watching similar others model appropriate behaviors and receive consequences for inappropriate behaviors (Hovell et al.). Recognizing that individual behavior is prompted by the ecological context in which one operates, social cognitive theory proposes that behavior, cognition (such as efficacy and perceived norms), and environmental context mutually reinforce

one another in a triadic relationship, and that this relationship can describe and predict adolescent risky-sex behaviors (Hovell et al.). According to this model, interventions that are most effective at decreasing instances of risky-sex behavior should provide information on STIs, HIV, and teen pregnancy, promote a realistic sense of efficacy, and increase social norms and skills related to safe sex behaviors. Through theater, the C.A.M.P. program provides information on early pregnancy, STIs (such as herpes), and HIV. The theater performance stresses the importance of personal control over sexuality and sexual behavior, and promotes the safe sexual practices of abstinence and consistent condom use as the responsible approach to sexual behavior. In addition, the theater performance promotes social norms that are favorable to the safe sexual behaviors of abstinence and condom use, and through modeling, provides skills on refusing sexual advances.

The theater troop consists of an ethnic cast of adolescents and young adult actors between the ages of 15 and 25. These individuals are recruited directly from the community via a series of open call auditions held in the summer at the CHOICES office. Aside from acting ability, actors are also chosen for their similarity to the target audience and knowledge of the surrounding community. Therefore, most of the performers are Latino, and have some existing knowledge of the demographic and cultural make-up of the target area. Most of the actors were born and have lived in the greater Los Angeles area for a significant amount of time. Prior to working with the target population, these adolescents and young adults are given three days of training on STIs, HIV/AIDS, teenage pregnancy, and the role that abstinence and consistent condom use play in maintaining adolescent sexual health. The actors also continue to receive educational workshops related to teen sexual health during the academic calendar theater session.

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Twelve different, but related, skits comprise the hour-long theatre performance. Skits used in the theater take two forms: 1) informational facts and 2) scene depictions. Five of the skits constitute facts that are read by actors on-stage in between scenes. These facts provide information about early pregnancy, STIs, and HIV/AIDS; for example, one such skit states, "Know the facts: Girls can become pregnant the first time they have sex."

The remaining skits are various depictions of adolescents encountering issues of sexual pressure, HIV/AIDS, STIs, and early pregnancy. These skits attempt to provide modeling of abstinence, consistent condom use, personal control (efficacy) over sexual health, and sexual refusal and negotiation skills. For example, one skit depicts a young Latina woman who is being aggressively kissed by her boyfriend. The scene portrays the young woman refusing sexual advances, and reinforcing that "no" means "no." Drawing from a community approach, the skits for the theater performance are derived directly from real-life situations individuals in the target audience encounter. The actors, alongside a Latina social worker, take an active role in skit development, and provide feedback to increase the realism of the performance. Often, the skits are based upon actual experiences of the cast members or individuals known to cast members.

Every attempt was made to be culturally competent. First, the actors cast represent the age and ethnic background of the participants. In addition, the intervention incorporates a number of references to different segments of Latino culture into the props and skits. The intervention is designed for the Latino adolescent community who resides in the greater Los Angeles area, and therefore the majority of the skits contain a mixture of "Spanglish" (words that are a mix of Spanish and English), code-switching (phrases that start in one language and finish in another), and English, in order to make the skits more representative of the conversational patterns of many of the bilingual youth of this community.

Furthermore, reference is made in several of the skits to traditional Latino cultural customs, such as the use of *curanderos* (healers). This is done in a manner that is respectful of cultural values, while simultaneously dispelling misconceptions and myths. For instance, one scene in the play depicts a Latina mother telling her daughter that *curanderos* can cure AIDS. The daughter in the scene tells her mother that, although *curanderos* are good for many things, there is no cure for AIDS. These types of cultural references show value of and respect towards cultural norms, and also work to dispel the myth that AIDS is curable.

Method

Participants

A total of 1613 adolescents in the eighth and ninth grades in seven schools in Southern California participated in the C.A.M.P. Teen Theater program during the 2000 to 2001 academic school year. Schools in the San Gabriel Valley were invited to participate in the intervention and evaluation. The schools in which the school board and principal gave permission for entry were selected for participation in the project. Students who elected to participate and had informed parental consent were selected from classrooms in which the teacher volunteered class time to participate in the study. There were about equal numbers of females (50.7%, $n = 805$) and males (49.3%, $n = 783$).[1] Participants' ages ranged from 11 to 18 with a mean age of 13.31 ($SD = .76$).

Table 1 details the ethnic make-up of the sample. The participants were primarily Latino (78.5%, $n = 1039$), many of who are immigrants or children of immigrants. In the group of adolescents served by the intervention, 26.3% ($n = 332$) are immigrants, 59% ($n = 746$) are first generation (participant was born in the United States, but both parents were born outside the U.S.), and 14.7% ($n = 186$) are second generation (participant and at least one parent was born in the U.S.). The majority of the adolescents (73.8%, $n = 934$) reported being fluent in a language

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other than English. Of the adolescents who reported speaking another language, 78.7% (n = 730) reported that Spanish was their native language.

INSERT TABLE 1 ABOUT HERE

Participants were asked to report the highest educational level achieved by their mothers and fathers. Of the 1304 participants (80.8%) who answered the question regarding their mothers, 32.7% (n = 427) of the participants reported they did not know their mother's educational level. Of the 1281 (79.4%) participants who answered the question regarding their fathers, 38% (n = 487) of the participants reported not knowing their father's educational level. For participants who knew their mother's (54.4%, n = 877) or father's (49.2%, n = 794) educational level, about a third of mothers (33.6%, n = 295) and fathers (33%, n = 262) attained less than an eighth grade education. This data suggests that the participants may be from a community of few economic resources; however, this conclusion should be interpreted with caution due to the high number of adolescents who could not provide information on their parents' educational level.

Materials

Participants completed a questionnaire prior to viewing the theater presentation that contained items on demographics, past sexual activity, and current contraceptive use. There were also questions on intentions to use contraceptives and intentions to postpone sex. Finally, questions assessing comfort with communication about sexual issues and knowledge of HIV and STIs, abstinence, and male responsibility were included in the questionnaire. The questionnaire took about 30 minutes to complete, with reading difficulty at the third grade level.

Behavioral Items. Participants completed several items on their past sexual activity, contraceptive use, and frequency of and comfort with communication about sexual issues. Past

sexual activity was measured by asking participants to either answer "yes" or "no" to the question, "Have you had sexual intercourse?" Participants responding "yes" were asked to provide their age at first sexual intercourse. Contraceptive use was assessed by asking participants to rate how often they used the pill, condom, diaphragm, "the shot" (Depo-Provera), or another method on a 5-point Likert scale ranging from 1 (*never*) to 5 (*every time*). Participants responding that they used another method were asked to indicate the method of contraceptive used. Participants' frequency of sexual communication was assessed by having participants rate, on a 5-point Likert scale ranging from 1 (*never*) to 5 (*always*), how often they talk about sex with each of the following people: parents, friends, and dating partners. Participants' comfort during sexual communication was measured by asking participants to rate, on a 5-point Likert scale ranging from 1 (*very uncomfortable*) to 5 (*very comfortable*) with a middle anchor of 3 (*indifferent*), how comfortable they felt while talking about sex with each of the following individuals: parents, friends, and dating partners.

Behavioral Intention Items. Participants answered two items assessing their intentions to postpone sex. Participants were asked to indicate their agreement with two statements, "I plan to wait to have sex until I am older" and "I plan to wait to have sex until I am married," on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) with a middle anchor of *can't decide*. These two items (r = .51) were combined to create a single score.

Knowledge Items. The questionnaire measured participants' knowledge of HIV and STIs. One statement, "I am aware that I can protect myself from sexually transmitted infections by using condoms," was measured on a Likert scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*) with a midpoint of 3 (*Can't Decide*). Four questions tested knowledge of HIV transmission such as "You can catch HIV or AIDS by sharing a drink or eating with someone,"

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on a 4-point Likert scale (1 = *Strongly Disagree* to 4 = *Strongly Agree*). Knowledge about the meaning of *abstinence* was measured by one multiple choice item, "What does abstinence mean?" Finally, knowledge about the meaning of *male responsibility* was measured by one multiple choice item, "What does male responsibility mean?" The posttest was similar to the pretest, except most of the demographic questions and questions regarding sexual activity and contraceptive use were omitted.

Response Rate. The response rate to any single item on the questionnaire was adequate. Most of the demographic, predictor, and dependent variables, had a response rate between 85% and 100%. This response rate is typical for questionnaires on adolescent sexual behavior, and is considered an acceptable response rate by most researchers (Catania, Gibson, Marin, Coates, & Greenblatt, 1990). Analyses were conducted to determine if any significant differences in demographic, predictor, or dependent variables between participants with complete data and participants with incomplete data. All analyses were nonsignificant indicating participants with missing data were not statistically significantly different from participants with complete data on demographics and dependent variables.

Procedure

Parental/guardian consent forms were distributed to participants in their classrooms approximately one week prior to viewing the theater program. All adolescents viewing the program and completing questionnaires were required to bring back a consent form signed by their parent or legal guardian stating that they were allowed to participate in the project.

Evaluation of the theater program took place over a three-day period. Participants completed pre-test questionnaires during academic class time one-day prior to viewing the theater performance. Steps were made to ensure that participants were given enough privacy to

complete the questionnaire. Participants were instructed to seat themselves apart from their peers, and did not share or discuss responses to the questionnaire with their peers during administration. Participants who had consent viewed the 1-hour theater performance the next day. Directly after the performance, participants had a 15-minute open-forum discussion with the program actors to answer questions and clarify topics relevant to the theater. On the third day, participants were administered the post-test questionnaire, after which they were debriefed and allowed to ask any remaining questions regarding the performance and/or topics covered.

Project staff completed matching of the pretests and posttests within one week of post-intervention questionnaire administration. Participants were assigned a unique identification number comprised of their gender, birth date, and the first letter of their mother's first name. Project staff successfully matched 961 (59.6%) of the pre- and post-intervention questionnaires. The attrition rate was primarily due to difficulty with matching pre- and posttests due to participants' omission of pertinent information (i.e., gender, birth date, and mother's first initial) for matching the pre- and posttests. A comparison of participants who completed both pre and posttests with participants who completed pretests only revealed no statistically significant differences in demographic variables or variables examined in the intervention effects analyses. Adolescents who did not complete both the pre and post-questionnaires were included in the descriptive statistics, but were dropped from all data analyses testing the effects of the intervention.

Design

The C.A.M.P. intervention is evaluated using a pretest-posttest with non-equivalent companion group design. In this design, traditional pretest-posttest analyses (i.e., paired t-tests) are conducted to determine if the intervention had an effect on the dependent variables. These

findings are compared with analyses computed for quasi-control groups to increase the validity of the initial paired t-test findings. This research design is useful when the use of control groups is not ethical or practical. In this quasi-experimental design, each school is matched with a similar school to form a pair, or a unit of analysis. The pretest data of one school in each pair serves as the control group and the posttest data of the other school in the pair serves as the experimental group (see Figure 1). The same analyses conducted with paired t-tests on pretest-posttest effects were conducted using independent t-tests between each matched pair of schools. Effect sizes were computed using the equation $r = \sqrt{[(t^2)/(t^2 + df)]}$ where r is the measure of effect size, t^2 is the square of the obtained t value, and df is the number of degrees of freedom (Rosenthal, 1984) for both statistical approaches for ease of comparison. The intervention was implemented for seven schools; however, only three pairs of schools could be matched for comparison. Since the seventh school did not have a comparison group, it was dropped from the pretest-posttest analyses, as well as the quasi-control group analyses. The seventh school was, however, included in descriptive analyses. The selection of the dropped school was determined by the a priori set criteria to select quasi-control groups.

INSERT FIGURE 1 ABOUT HERE

Selection of quasi-control groups. There were 21 possible pairs of schools for the experimental and control group comparisons. A systematic approach was taken to reduce personal and systematic bias in the a priori selection of the three pairs of schools. The schools were matched using an algorithm (see discussion in Scriven, 1991) to pair schools that fit an a priori set of criteria. The criteria for the present study were (listed in order of importance): proximity of dates of intervention, age similarity, sample size, and gender make up. The first criterion was that experimental groups must temporally precede the control groups in terms of

date of intervention implementation. This stipulation reduced the time delay between control and experimental groups as much as possible, thereby allowing to control for history effects. The second criterion required that the mean age of participants in each possible pair of schools must be less than a one-year difference. This criterion was used because older adolescents may be more likely to have had sex, and therefore may not be comparable to younger adolescents. The third criterion required similar sample sizes, where a potential pair could not have a difference of more than 100 participants. The fourth criterion was that the ratio of females and males in each school within the pair could not be greater than 2:1. For example, in pair one, school A had 113 females, compared to school B, which had 73 females, producing a ratio less than 2:1. Table 2 details the criterion variables of each pair of schools selected.

INSERT TABLE 2 ABOUT HERE

Results

Sexual Activity

Participants were asked if they have ever had sexual intercourse, and if so, at what age. Responses indicated that out of the sample of 1613 adolescents, 8.5% (137) of participants had sexual intercourse. The average age of first intercourse was 12.52 years (SD = 1.49, Range 6-16). Of the participants who reported having had sex, 67.2% (92) were male and 31.4% (43) were female.[2] There was no significant difference in age of first intercourse between males (M =12.40, SD = 1.74) and females (M = 12.76, SD = .72).

Contraceptive Use. Participants were asked to report how often they use various forms of birth control, including the pill, condoms, diaphragm, the shot, or another method. Of the 137 participants who had ever had sex and reported contraceptive use, the majority reported never using the pill (80%, n = 72), diaphragm (82.8%, n = 72), the shot (88.8%, n = 79), or another

method (94.3%, $n = 33$). The percentage of participants who reported using condoms every time they had sex was 53.5% ($n = 61$). Table 3 provides the frequency of contraceptive use among the sexually active participants.

INSERT TABLE 3 HERE

Intervention Impact

Delaying Intercourse. Participants were asked if they would postpone sexual intercourse until they were older or until they were married. The items were combined to create a mean intention to delay score, and had a correlation of .51 ($p < .001$). The paired t test indicated participants were significantly more likely to intend to postpone sex at the posttest ($t(703) = 11.17, p < .001; r = .388$). The quasi-experimental analyses rendered further support for this finding. All three experimental groups were significantly more likely to intend to postpone sex compared to the control groups (pair 1: $t(238) = 4.87, p < .001; r = .30$; pair 2: $t(195) = 3.78, p < .001; r = .26$; pair 3: $t(171) = 3.85, p < .001; r = .28$).

Communication. The intervention had an impact on participants reported comfort with communication with their mothers. At the posttest, ratings of comfort increased significantly ($t(785) = 2.63, p < .01; r = .093$). The quasi-experimental analyses provided some support for this finding. Pair number two of the comparison schools yielded a significant increase in comfort in communication with mothers ($t(211) = 2.88, p < .01; r = .19$). The pretest posttest analysis indicated a significant increase in comfort with communicating with friends ($t(770) = 2.16, p < .05; r = .077$) upon posttesting. However, the quasi-experimental analyses did not support this finding. Comfort with participants' communication with boyfriends/girlfriends, fathers, and others did not significantly increase at the posttest. See Table 4 for the frequencies of comfort with communication at pretesting and posttesting.

INSERT TABLE 4 HERE

HIV Knowledge. Upon posttesting, participants demonstrated a significant increase in knowledge regarding how HIV is transmitted and how it can be prevented $t(865) = 4.92, p < .001; r = .16$). This finding was supported by two of the three quasi-control group comparisons (pair 1: $t(563) = 4.16, p < .001; r = .17$; pair 3: $t(219) = 3.38, p < .01; r = .29$).

Abstinence Knowledge. There was an increase in the number of participants who correctly responded to the item, "What does abstinence mean?" On the pretest, 49% (375) of the participants correctly responded that abstinence waiting and not having sex until one is ready. On the posttest, 64.9% (543) of respondents answered the question correctly. Table 5 details the participants' responses regarding abstinence. There was a significant difference between the pre- and posttest distributions of participants' responses to the definition of abstinence ($\chi^2(9, N = 751) = 217.87, p < .001$).

INSERT TABLE 5 ABOUT HERE

Male Responsibility Knowledge. There was an increase in the number of participants who correctly responded to the item, "What does male responsibility mean?" On the pretest, 66.5% (545) of the participants correctly responded that male responsibility meant, not having sex, using a condom if you do, and providing support for your child in the event of a pregnancy. On the posttest, 76.4% (649) of respondents answered the question correctly. There was a significant difference between the pre- and posttest distributions of participants' responses to the definition of male responsibility ($\chi^2(9, N = 800) = 400.99, p < .001$).

Discussion

Overall, these findings indicate that the C.A.M.P. Teen Theater program was effective in its aims to provide accurate information on safe sexual behaviors and to promote behavioral

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intention change. Adolescents participating in the intervention reported increased knowledge of the role of condoms in preventing STI transmission. Those participating in the intervention also reported increased intentions to abstain from early sexual behavior, and to use contraceptives once becoming sexually active.

The pre-questionnaire findings indicated low rates and uncomfortable communication about sexual issues between adolescents and their dating partners and adolescents and their parents. The fact that this finding was found in both the present study and in Guzmán and associates' (2001) sample of older adolescents suggests that communication patterns might not change drastically from early to mid adolescence. The majority of these communication patterns did not significantly change post-intervention. However, participants did report feeling more comfortable when communicating about sex with their mother after watching the theater presentation. Therefore, although the majority of adolescent communication patterns about sexual behavior appear to be unaffected by a brief sexual education intervention, the finding that perceived comfort of adolescent-mother communication increased post-intervention suggests that sexual education programs can work to promote positive communicative change.

The results indicate that C.A.M.P. was highly effective at both increasing participants' knowledge about HIV and the role of contraceptives in preventing STIs. Effect sizes for the informational items ranged from $r = .18$ for HIV knowledge to $r = .39$ for the importance of contraceptives. Furthermore, adolescents participating in C.A.M.P. were significantly more likely to report greater intentions to both delay intercourse and to use contraceptives if becoming sexually active post-intervention. Effect sizes on the behavioral items were moderately high. When these effect sizes are considered in terms of practical significance, or real life impact, the effect sizes suggest that C.A.M.P. could have a broad and very noticeable positive impact on the

public health of this population. These results highlight the effectiveness of non-traditional educational programs in producing behavioral intention change. The knowledge that traditional, information-based sexual health promotion programs generally do not yield significant degrees of behavioral intention change suggest that non-traditional programs, such as C.A.M.P., are an important contribution to sexual education, above and beyond that traditionally provided.

It is posited that the success of the C.A.M.P. program lies in its community focus and use of the behavioral ecological model to promote responsible sexual behavior. The program's inclusion of culturally and developmentally appropriate language and cultural references increases its realism. Adolescents are better able to relate to the actors, thus enabling the participants to learn about safe sex practices through modeling. The use of peers as models is thought to impact adolescents' perceptions of their own peer norms as promoting safe sex behavior.

Recommendations for Future Program Implementation

Although the C.A.M.P. program has been successful in promoting safe sexual health behaviors among ethnic youth, more programs are needed to significantly and positively impact the sexual health outcomes of this population. Often, programs (especially those that are school-based) are implemented with limited budgets and time constraints. These limitations no doubt influence the effectiveness of programs such as C.A.M.P. Indeed, several aspects of the C.A.M.P. program and implementation design could be augmented to increase the effectiveness of the program. Based on community psychological research as well as the authors' own experience with implementing non-traditional sexual health promotion programs, recommendations for future program development and implementation are made. First, to increase the likelihood that behavioral intentions translate into actual behavior, an interactive

component should be included. Interactive activities include workshops, or one-on-one coaching sessions, where adolescents have the opportunity to develop their sexual negotiation skills through role-play and more intimate discussion of safe sex behavior. Furthermore, the implementation of a simultaneous large-scale condom distribution program among the participants would increase the probability that adolescents' sexual behavior intentions to use contraceptives would lead to actual contraceptive use. Adolescents may have intentions to use condoms consistently, however, if they are unable to obtain condoms cheaply, easily, and discreetly, these intentions may not be realized.

Ethnic adolescents are disproportionately affected by the negative sexual health outcomes of STI and HIV contraction and early pregnancy. This increased risk is due mainly to unsafe sexual practices such as early and unprotected instances of sexual activity. Although many public schools currently have sex education curricula in place, these programs often focus purely on transmitting knowledge, which is insufficient at promoting safe sexual behaviors change (Bandura, 1992; Hogben & Byrne, 1998; Kirby, 1985, 2000; McDermott, 1998). In addition, ethnic adolescents have been identified as being in need of interventions to promote safe sexual health behaviors. Non-traditional programs with a community focus, such as C.A.M.P., show promise in extending the current sex education curricula and promoting safe sexual health practices among ethnic youth.

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Footnotes

[1] Twenty-five adolescents did not report their gender.

[2] Two participants did not report their gender.

Table 1. Participants' Ethnicity

	Frequency	Percent
African American/Black	55	4.2%
American Indian/Native American	18	1.4%
Asian/Pacific Islander	116	8.8%
Hispanic/Latino/Mexican	1039	78.5%
White/Caucasian	25	1.8%
Other	16	1.2%
Multiethnic	54	4.1%
Total	1323	100.0%

Table 2. Quasi-control Comparison Schools

Pair	Group	C.A.M.P. Schools	Total # of Participants	Date of C.A.M.P. Intervention	Mean Age	Number of Females	Number of Males	Number with Gender Missing
1	Experimental	School A	171	11/20/2000	13.18	113	58	0
	Control	School B	151	12/4/2000	13.06	73	77	1
2	Experimental	School C	53	2/5/2001	13.24	26	26	1
	Control	School D	120	2/9/2001	13.25	71	48	1
3	Experimental	School E	125	3/12/2001	13.34	76	49	0
	Control	School F	191	3/23/2001	13.45	99	92	0
	Non-matched School	School G	150	12/18/2000	14.28	84	65	0
		TOTAL	961	11/20/2000-3/23/2001	13.42	542	415	3

Table 3. Type and Frequency of Contraceptive Use Among Sexually Active Adolescents

	NEVER		RARELY		SOMETIMES		MOST TIMES		EVERY TIME	
	N	%	N	%	N	%	N	%	N	%
Condom (n = 114)	20	17.6	9	7.9	12	10.5	12	10.5	61	53.5
Pill (n = 90)	72	80.0	7	7.8	4	4.4	2	2.2	5	5.6
Diaphragm (n = 87)	72	82.8	3	3.4	3	3.4	6	7.0	3	3.4
The Shot (n = 89)	79	88.9	1	1.1	2	2.2	2	2.2	5	5.6
Other (n = 35)	33	97.0	0	0.0	0	0.0	0	0.0	1	3.0

Table 4. Perceived Comfort of Discussion About Sexual Issues by Recipient of Communication

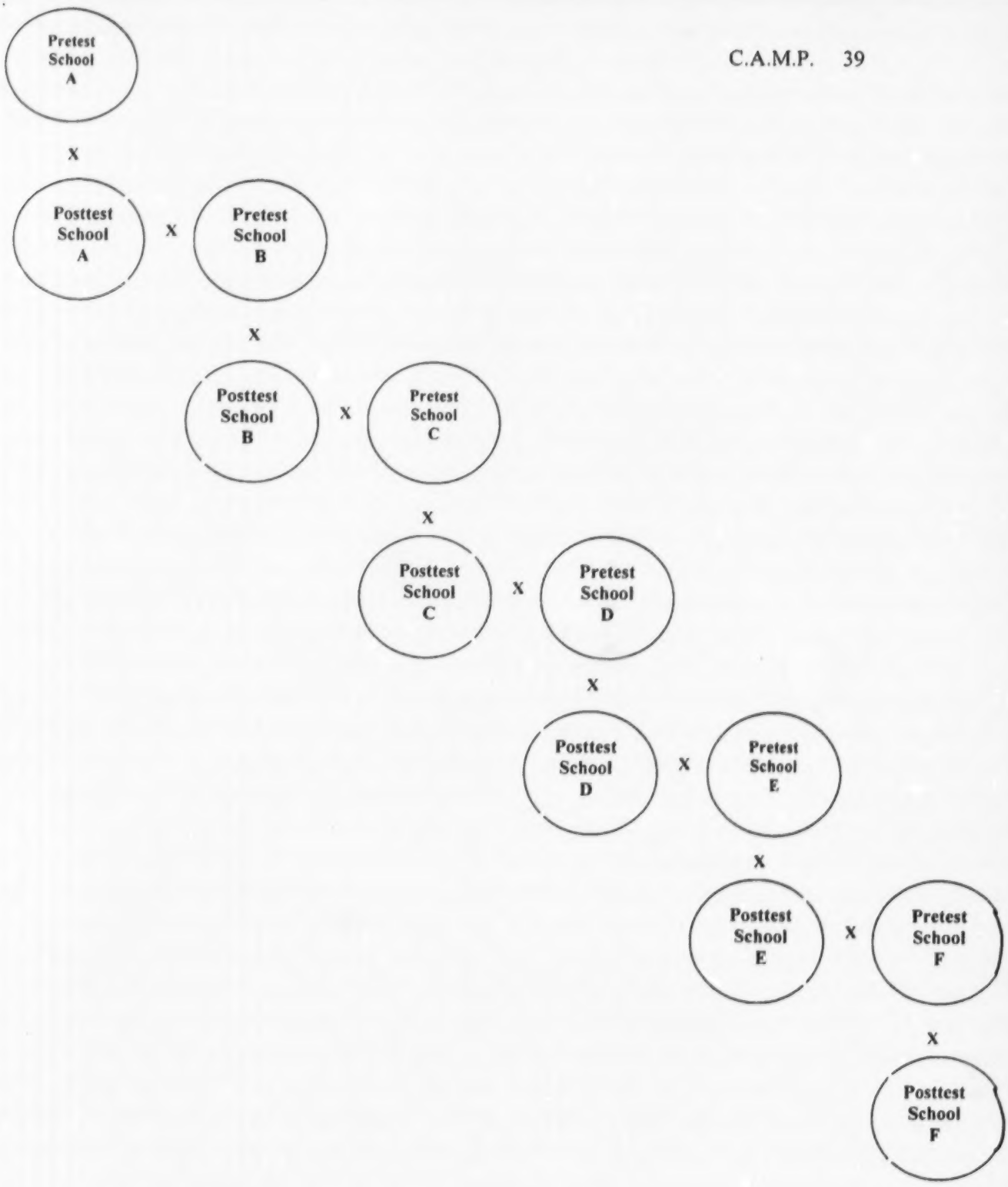
		UNCOMFORTABLE		COMFORTABLE	
		N	%	N	%
Pretest	Mother (N = 1211)	677	55.9	534	44.1
	Father (N = 1175)	838	71.3	337	28.7
	Friends (N = 1200)	343	28.6	857	71.4
	Boy/Girlfriend (N = 1151)	554	48.2	597	51.8
	Other (N = 502)	124	24.7	378	75.3
Posttest	Mother (N = 1124)	608	54.1	516	45.9
	Father (N = 1101)	777	70.5	324	29.5
	Friends (N = 1115)	253	22.7	862	77.3
	Boy/Girlfriend (N = 1055)	495	47.0	560	53.0
	Other (N = 537)	116	21.6	421	78.4

Table 5. Responses to "What Does Abstinence Mean?"

	HAVING SEX		HAVING SEX DURING MENSTRUATION		HAVING SEX WITHOUT PROTECTION		WAITING AND NOT HAVING SEX	
	N	%	N	%	N	%	N	%
Pretest	67	8.8	116	15.2	207	27.0	375	49.0
Posttest	77	9.1	70	8.4	147	17.6	543	64.9

Figure Caption

Figure 1. Relationship Between Pretest and Posttest for Schools in the C.A.M.P. Program


Pretest School A
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Pretest School F
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Posttest School F

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